STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: 4/23-4/26/12 Facility number: 000404 Provider number: 155512 Aim number: 100290810 Survey team: Carol Miller RN, TC Honey Kuhn RN Christine Fodrea RN Tim Long RN Shelly Vice RN, (4/23-4/25/12) Julie Wagoner RN Census bed type: SNF/NF: 103 SNF: 16 Total: 119 Census payor type: Medicare: 9 Medicaid: 75 Other: 35 Total: 119 Sample: 24 These deficiencies also reflect State findings cited in accordance with 410 IAC	F0000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Provena Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Provena Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of complaince.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2. Quality review completed 5/1/12 Cathy Emswiller RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to inform the physician of pressure ulcers for 2 of 5 (#95, 103) residents reviewed for pressure ulcers in a sample of 24.	F0157	The facility will continue to monitor and treat the pressure ulcer for resident #95 until resolved. Resident #103 pressure area has resolved on his heal on 5-8-2012. The corrective	05/18/2012

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	Findings include: 1. Resident # 95's clinical record was reviewed 4/23/12 at 11:30 A.M.. The record indicated the resident was admitted to the facility on 6/20/07 and had diagnoses including, but not limited to, Alzheimer's disease, congestive heart failure and renal failure. Review of the resident's nurse's notes from 1/23/12 at 9:08 P.M. indicated "Follow up from Podiatry clinic. Noted on right great toe, distal top, area pinkish red. Blister like intact area present. Skin rough to touch". Review of the Podiatry progress not from 1/23/12 indicated a pressure area noted distal right great toe. The pressure ulcer assessment form from 1/25/12 indicated the would was 0.7 centimeters (cm) x 1.0 cm, dry scab. The wound was unstageable. On 2/1/12 at 1:11 P.M. a nurse's note indicated a 60 day check was completed by the physician and the resident's right great toe was assessed with no changes. An observation on 4/24/12 at 11:40 A.M. of the right great toe indicated to top of		action to prevent other residents from being affected by the deficient practice is when a pressure ulcer is discovered the nurse who discovered the pressure ulcer will initiate the pressure ulcer assessment form and push tool, see attached.When a pressure ulcer is found the physician and POA/guardian will be notified. The pressure ulcer will be documented and care planned. Treatment and wound measuring is done weekly on day shift. After the weekly documentation and care plan update the pressure ulcer assessment form will be filed on the resident chart.Inservice training for staff will be completed by 5-18-2012 on the initiation process of the physician notification of a new pressure area. The DON or designee will review charting for residents with pressure sores ongoing to verify that physicians are notified of resident pressure areas.Unit Nurse responsibleQA Nurse to monitor and report to QA team monthly for additional monitoring	

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	the toe with a approximately 0.5 cm x 0.4 cm blackened area, no drainage, tissue surrounding wound pink and blanchable. An interview with RN #1 on 4/25/12 at 10:45 A.M. indicated no notification of the physician of the pressure ulcer to the resident's right great toe was located prior to 2/1/12. An interview with the Director of Nursing (DN) on 4/26/12 at 3:00 P.M. indicated no notification of the physician of the pressure ulcer to the resident's right great toe was located prior to 2/1/12. 2. During the initial tour of the facility, conducted on 04/23/12 between 11:00 A.M. - 11:30 A.M., R.N. #2, the Unit Manager, indicated Resident #103 had an unstageable pressure ulcer on his right heel. She indicated he had been admitted with a blister on his right heel from an acute care center following surgical repair of a fractured left hip. Resident #103 was observed on 04/23/12 at 12:13 P.M., seated in his wheelchair in the dining room/lounge on the rehab unit. The resident was noted to have a quilted bootie on his right foot and a dressing was visible on the heel area. Resident #103's pressure ulcer was			

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	observed on 04/24/12 at 2:45 P.M. The resident had a rounded, silver dollar sized pressure ulcer on the bottom posterior side of his right heel. The bottom portion of the wound was a dried, brown colored fluidless blistered area the top 1/3 and a portion above the blister was noted to be covered with black, thick tissue. RN #2 indicated she would call the black area, eschar. The eschar area covered the entire top 1/3 of the original blistered area, was shaped like a button mushroom cap, and was thick and visibly rimmed on one side of the eschar area. The top of the resident's foot and toes were pink in color. The clinical record for Resident #103 was reviewed on 04/23/12 at 2:30 P.M. Resident #103 was admitted to the facility on 04/06/12 from an acute care facility with diagnoses, including but not limited to, status post left hip fracture repair, atrial fibrillation, history of a cerebral vascular accident, hypertension, and constipation. Review of an electronic Admission Assessment, completed on 04/07/12 at 2:46 A.M., by RN #4, indicated under section i. "Integumentary" the resident's skin was noted as pale in color, a bruise and incision were documented. Although there was a place to document a blister, hematoma, or pressure ulcer, none were			

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	noted. In addition, review of nursing progress notes, completed by RN #4, on 04/06/12 at 11:48 P.M., and RN #3 on 04/07/12 at 4:09 P.M., indicated both nurses documented an assessment of all of the resident's systems and body, but failed to document a blister or impaired skin on the resident's right heel. A "skin condition flowsheet", completed by RN #4, dated 04/06/12 indicated the presence of a hematoma "ota" (open to air) intact elevated with sheepskin. Review of the admission physician's orders, dated 04/06/12, indicated there were no specific orders related to the care and/or treatment of a blister on the resident's right heel. The transfer documentation from the acute care center did not mention a pressure ulcer or blister on the resident's right heel. A nursing progress note, dated 04/07/12 at 10:55 P.M. indicated the following: "...On res (resident's) right heel there is a hematoma that measures 4.5 x 5.4 x<.1. (centimeters) Heel was placed in sheep skin protector..." There was no documentation the physician was notified of the resident's pressure ulcer.			

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	Review of a treatment record for April 2012 for Resident #103 indicated a pressure relieving mattress was implemented on 04/06/12, and "Monitor hematoma to rt heel et (and) elevate with sheep skin on when in bed" was implemented on 04/07/12, a heel protector at all times was implemented on 04/10/12, and keep right lower extremity elevated in bed/wheelchair was implemented on 04/10/12. There was no documentation the physician was notified of the blister on the resident's right heel until an order for a specific treatment was received on 04/13/12. Interview with the Director of Nursing, on 04/25/12 at 9:00 A.M., indicated Resident #103 had been admitted to the facility on 04/06/12 with the blister to the right heel. A document obtained from the acute care facility, indicated the resident had a blister noted on 04/04/12. In addition, a note signed by the physician indicated he visited the resident at the facility on 04/08/12 and was aware of the resident's right heel blister. The Director of Nursing, on 04/25/12 at 9:00 A.M. indicated the Admission Assessment, completed by RN #4 on 04/07/12 was inaccurately documented			

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	and she did not know why RN #3 and #4 did not mention the presence of a pressure ulcer in the progress notes until 04/07/12 at 10:55 P.M. 3.1-5(a)(1)			

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F0221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on interviews, observations, and record review, the facility failed to follow the Care Plan in regard to the release of a restraint during activities. This deficiency affected 1 of 1 resident reviewed for restraints in a sample of 24 (Resident #62). Findings include: The clinical record of Resident # 62 was reviewed on 4/23/12 at 12:00 p.m. and indicated Resident #62's diagnoses included, but were not limited to, Alzheimer's disease and anxiety and hallucinations. The Physical Restraint Assessment form dated 11/29/11 indicated a padded laptop cushion to her wheelchair was recommended by Physical Therapy due to the residents safety, poor balance and frequent falls. The alternatives had already been tried for the resident were 1 on 1 supervision, activities, medications for anxiety and a merry walker. The Quarterly Restraint Effectiveness	F0221	Corrective action taken; the activity care plan on resident #62 was updated on 5-7-2012, the restraint care plan was updated for resident #62 on 5-8-2012. For resident having the potential to be affected by the deficient practice their care plans will be reviewed at least quarterly or with a significant change of condition. Nursing staff will monitor residents that are on restraints daily by nursing documentation. Inservice will be provided to staff on care plan updates by 5-18-2012. The DON or designee will observe residents with restraints to verify that restraints are implemented in accordance with residents' care plans ongoing. Nurse is responsibleDON to monitorQA Team will monitor monthly	05/18/2012

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	report dated 2/20/12 indicated the padded laptop cushion had not fallen and had increased the residents independence. The Care Plan in regard to the padded laptop cushion dated 11/29/11 indicated to provided the resident with an activity program "...where 'restraint free' time can be provided " The Care Plan further indicated to apply the lap top cushion restraint to the resident if the resident had become restless to allow the resident with "...self mobility" and to release the restraint every 2 hours for 15 minutes. On 4/24/12 at 9:15 a.m. the resident was observed in the unit's dining room seated in a wheelchair with the padded laptop cushion over the resident's lap with Activity Aide #5 present. The resident was alert and calm. On 4/24/12 at 4:15 p.m. the resident was observed in the unit's dining room seated in a wheelchair with the padded laptop cushion on over the resident's lap. The resident was observed to be in an activity with Activity Aide #7 present. On 4/25/12 at 2:50 p.m. LPN # 6 was interviewed in regard to the residents laptop cushion restraint and indicated yesterday right after the resident ate breakfast the resident was			

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	transferred from the comfort chair to the wheelchair and the laptop cushion restraint had been applied due to the resident had tried to put her feet over the side of the comfort chair and climb out of the chair. LPN #6 indicated when the resident had become restless the staff intervened with 1:1 activities and a snack was tried prior to applying the laptop cushion to the resident's wheelchair. LPN #6 indicated the resident is not always easily redirected and the staff on the unit had released from the laptop cushion every 2 hours. On 4/25/12 at 3:00 p.m. QMA #8 was interviewed in regard to the resident's laptop cushion restraint and indicated the laptop cushion restraint should be released when the resident is in a supervised activity. On 4/26/12 at 1:15 p.m. Activity Aide #5 was interviewed in regard to the resident's padded lap top cushion present during activities. The Activity Aide #5 indicated the resident can be so unpredictable in regard to her movements and at times the resident becomes very anxious. The Activity Aide #5 indicated the resident had been more sleepy this week. 3.1-26(h)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure 1 of 8 possible	F0225	All abuse, neglect or mistreatment allegations will be throughly investigated and	05/18/2012

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	abuse, neglect, or mistreatment allegations were thoroughly investigated and reported promptly to other officials in accordance with State law. Findings include: During a routine interview for abuse/neglect procedures RN #1 indicated an incident which occurred approximately 3 months ago where resident #34 said he was beat up by some guy during the night. On 4/26/12 at 9:00 A.M. the Director of Nursing (DON) provided a document dated 1/9/12 at 12:30 A.M. from the facility Administrator which indicated resident #34 "saying that a guy beat him up last night". LPN #9 reported the resident had a small bruise left deltoid and lower left leg. LPN #9 reported the resident is restless while being transferred via stand up lift with 2 staff assist and he is restless in bed. The document indicated at 1:00 P.M. LPN #9 contacted the Administrator and stated the resident's family was in for lunch and she told them what the resident had been saying about being beat up. LPN #9 reported the family stated the resident used to say that all the time at the previous nursing home he was at. The document continued, "based on resident minor extremity bruising, resident diagnoses, staff interview and		reported promptly to Administrator and officials in accordance with state law. The abuse policy was updated on 4-25-2012, see attached. The abuse investigation form will be completed and submitted as required. Staff will be inserviced on the abuse policy by 5-18-2012. Any unusual occurrences, abuse, neglect or mistreatment allegations and suspicion of crime will be brought to the QA team monthly for review. The administrator will review abuse, neglect, or mistreatment allegations, unusual occurrences, and suspicion of crimes ongoing to ensure proper investigation and reporting procedures are being followed.Administrator responsibleAdministrator will monitorQA Team will monitor monthly	

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	family statement, this 'alleged' incident did not occur". An interview with the Administrator on 4/26/12 at 10:30 A.M. indicated they interviewed the CNA's working during the alleged incident but didn't include the information because the family said the resident had stated similar things in the past and the incident was not reported to the Indiana State Department of Health (ISDH). An interview with the DON on 4/26/12 at 11:00 A.M. indicated she felt the incident of 1/9/12 did not need to be reported as the family reported the information about the resident's past allegations of being beat up during the night 1/2 hour after the investigation started. The DON also indicated they were initially going to suspend CNA #10 pending the outcome of the investigation but CNA #10 was not scheduled to work the next day anyway. Review of the facility policy "Reporting and investigation of neglect and/or mis-appropriation of resident property" dated 5/12/05 indicated under section 1., reporting of abuse, neglect, administration responsibilities: "the administrator/designee, on becoming aware of alleged abuse, neglect and/or misappropriation of a resident's property,			

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	shall report the matter immediately by telephone to the following: a. the resident's representative; b. Regional Office of the Indiana Department of Public Health (Utilize the Hot Line on weekends/holidays); c. Resident physician; d. Local Ombudsman; e. Local police department (if sexual or physical abuse). Section II, investigation of abuse, neglect, misappropriation of property included: "The investigation will include, but was not limited to: "date, time, place, circumstances surrounding the occurrence by interviewing appropriate parties. Interviews will be conducted as early as possible following an alleged incident; names of resident, employee(s), witness(s) providing statements and copies of their written statements". Under section III. B. employee as perpetrator: "the employee is immediately suspended (with pay) from duty pending the outcome of the investigation". 3.1-28(c)(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to ensure the Abuse policy was implemented for 1 of 8 possible abuse, neglect, or mistreatment allegations were thoroughly investigated and reported promptly to other officials in accordance with State law (Resident #34). Findings include: During a routine interview for abuse/neglect procedures RN #1 indicated an incident which occurred approximately 3 months ago where resident #34 said he was beat up by some guy during the night. On 4/26/12 at 9:00 A.M. the Director of Nursing (DON) provided a document dated 1/9/12 at 12:30 A.M. from the facility Administrator which indicated resident #34 "saying that a guy beat him up last night". LPN #9 reported the resident had a small bruise left deltoid and lower left leg. LPN #9 reported the resident is restless while being transferred via stand up lift with 2 staff assist and he is restless in bed. The document indicated	F0226	All abuse, neglect or mistreatment allegations will be thoroughly investigated and reported promptly to the administrator and officials in accordance with state law. The abuse policy was updated on 4-25-2012, see attached. The abuse investigation form will be completed and submitted as required. Staff will be inserviced on the updated abuse policy by 5-18-2012. Any unusual occurrences, abuse, neglect or mistreatment allegations and suspicion of crime will be brought to the QA team monthly for review. The administrator will review abuse, neglect, or mistreatment allegations, unusual occurrences, and suspicion of crimes ongoing to ensure proper investigation and reporting procedures are being followed. Administrator responsibl eAdministrator will monitorQA Team will monitor monthly	05/18/2012

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	at 1:00 P.M. LPN #9 contacted the Administrator and stated the resident's family was in for lunch and she told them what the resident had been saying about being beat up. LPN #9 reported the family stated the resident used to say that all the time at the previous nursing home he was at. The document continued, "based on resident minor extremity bruising, resident diagnoses, staff interview and family statement, this 'alleged' incident did not occur". An interview with the Administrator on 4/26/12 at 10:30 A.M. indicated they interviewed the CNA's working during the alleged incident but didn't include the information because the family said the resident had stated similar things in the past and the incident was not reported to the Indiana State Department of Health (ISDH). An interview with the DON on 4/26/12 at 11:00 A.M. indicated she felt the incident of 1/9/12 did not need to be reported as the family reported the information about the resident's past allegations of being beat up during the night 1/2 hour after the investigation started. The DON also indicated they were initially going to suspend CNA #10 pending the outcome of the investigation but CNA #10 was not scheduled to work the next day anyway.			

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	Review of the facility policy "Reporting and investigation of neglect and/or mis-appropriation of resident property" dated 5/12/05 indicated under section 1., reporting of abuse, neglect, administration responsibilities: "the administrator/designee, on becoming aware of alleged abuse, neglect and/or misappropriation of a resident's property, shall report the matter immediately by telephone to the following: a. the resident's representative; b. Regional Office of the Indiana Department of Public Health (Utilize the Hot Line on weekends/holidays); c. Resident physician; d. Local Ombudsman; e. Local police department (if sexual or physical abuse). Section II, investigation of abuse, neglect, misappropriation of property included: "The investigation will include, but was not limited to: "date, time, place, circumstances surrounding the occurrence by interviewing appropriate parties. Interviews will be conducted as early as possible following an alleged incident; names of resident, employee(s), witness(s) providing statements and copies of their written statements". Under section III. B. employee as perpetrator: "the employee is immediately suspended (with pay) from duty pending the outcome of the investigation".			

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	3.1-28(a)			

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F0252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observations and interviews, the facility failed to ensure the private Resident bathrooms' bed pan sprayers were properly maintained and were attached firmly to the wall-storage-connecters. This potentially affected 3 of 3 in a sample of 3 (#51, #62 and #23) residents who utilized the sampled Resident's private bathroom's. Findings include: On 4/25/12 from 10:10 a.m. until 12:45 p.m. an environmental tour was conducted along with the Maintenance Director. On observation was made during the environmental tour of the each private bathroom located within the Residents' rooms. A bed pan sprayer was observed in the Resident's bathrooms. The private Resident bathrooms measure approximately four feet by six feet and include a one seated commode. The bed pan sprayer is a hand held water spraying device designed to spray pressurized water from the water source through a	F0252	The bed pan sprayers were all removed from the private and semi-privatre residents bathrooms. All fixtures will be cleaned and capped by 5-15-2012. Maintenence will complete an environmental checklist weekly on all neighborhoods to ensure and monitor proper maintenance throughout the facility.Property Manager responsible Property Manager to monitor	05/15/2012

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	hose. It was located above seated head height on the left handed side of the wall. The hand held sprayer was bulky, resembled an aged operation and was heavier in weight when held. The mechanical makeup of the hand held device was activated by the pressing of an attached lever with hand grasp allowing the flow of pressurized water to be released. The mechanics also include a storage handle located approximately four feet from the floor. This storage handle was used to perch the hand held sprayer onto between uses. The storage of the hand held sprayer balances upon the perch. On 4/25/12 at 11:05 a.m. an observation was made of a bed pan sprayer in room #13 of the Saint (St.) Claire unit. The hand held sprayer was missing the attached lever for activating the pressure release for water use. A lever and two screws were lying on the toilet tank lid. On 4/25/12 at 11:06 a.m. an interview with the Maintenance Director indicated the lever belonged to the bed pan sprayer and looked "broken." On 4/25/12 at 11:07 a.m. an interview with the Maintenance Manager for St. Claire unit indicated a work order for repair had not been completed.			

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	On 4/25/12 at 11:08 a.m. an observation was made of the flooring in room #13 of the St Claire private Resident bathroom. An observation was made of the floor directly underneath the storage handle for the bed pan sprayer. It was observed to have numerous concave indented gashes in the linoleum type flooring. On 4/25/12 at 11:08 a.m. an interview with the Maintenance Manager for St. Claire was conducted. When questioned about the formation of the gashes, it was affirmed by the Maintenance Manager this had resulted from the hand held sprayer falling off of the handle designed for perching the sprayer for storage. When interviewed about the uses of the hand held sprayers the Maintenance Manager of St. Claire indicated the Residents usage of the bed pan sprayers to be currently used. On 4/25/12 at 11:08 a.m. an interview with the Maintenance Director was conducted regarding the potential hazard of the hand held bed pan sprayer falling from the storage handle and physically hitting a Resident. The Maintenance Director indicated it was a possibility. "... Yes, I see what you mean, it is a possibility..." It was also stated at that time that this particular portion of the			

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	building was built in "1977" and the mechanics of the bed pan sprayers were "...old and parts cannot be ordered any longer...." On 4/25/12 at 11:15 a.m. an observation of room #17 of the Saint (St.) Francis unit was conducted. It was observed that the bed pan sprayer located in the Resident's private bathroom to be broken and the "cipher brake" to be dripping water. The lever for pressing to activate the pressurized water was missing from the sprayer. The Maintenance Director noted the dripping water and indicated the "... packing needs to be tightened as well ..." On 4/25/12 at 11:30 a.m. an observation of room #11 of the Saint (St.) Paul unit was conducted. The bed pan sprayer of the Residents private bathroom was observed. The lever to the sprayer was noted to be awkward. Upon interview with the Maintenance Director is was confirmed that the lever handle was on "... backwards..." On 4/25/12 at 11:35 a.m. an observation was made for room #4. The Resident of room #4 of the St Paul unit was using the private Resident bathroom and the roommate of the same room was awaiting to use the Resident bathroom.			

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	On 4/25/12 at 12:15 p.m. an interview with the Maintenance Director and Maintenance Manager of the St. Claire unit was made indicating, "... maintenance rounds are made every Monday... and the bed pan sprayers were all working fine then... " On 4/25/12 at 4:15 p.m. an interview with the Administrator, DNS and Assistant Administrator was conducted. It was indicated that the bed pan sprayers were not a potential hazard for the Residents due to the factor that the private Resident bathrooms were not being used for private Resident usage. On 4/26/12 at approximately 11:00 a.m. an interview was conducted with the Administrator, the Assistant Administrator and the DNS. It was indicated that the St. Claire unit was actively using only one private Resident bathroom; the St. Francis unit did not use the private Resident bathrooms at all; the St. Paul and the St Anthony units used the private Resident bathrooms "...most of the time..." 3.1-19(a)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations and interviews the facility failed to ensure the private Resident bathrooms' bed pan sprayers were properly maintained and were attached firmly to the wall-storage-connecters. This potentially affected 3 of 3 (#51, #62 and #23) of the Residents whom utilized the sampled Resident's private bathroom's. Findings include: On 4/25/12 from 10:10 a.m. until 12:45 p.m. an environmental tour was conducted along with the Maintenance Director. On observation was made during the environmental tour of the each private bathroom located with in the Residents' rooms. A bed pan sprayer was observed in the Resident's bathrooms. The private Resident bathrooms measure approximately four feet by six feet and include a one seated commode. The bed pan sprayer is a hand held water spraying device designed to spray pressurized	F0323	The bed pan sprayers were removed from private and semi-private resident bathrooms. All fixtures will be cleaned and capped by 5-15-2012. Maintenance will complete an environmental checklist on all neighborhoods weekly to ensure and monitor proper maintenance throughout the facility.Property Manager responsible Property Manager will monitor	05/15/2012

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	water from the water source through a hose. It was located above seated head height on the left handed side of the wall. The hand held sprayer was bulky, resembled an aged operation and was heavier in weight when held. The mechanical makeup of the hand held device was activated by the pressing of an attached lever with hand grasp allowing the flow of pressurized water to be released. The mechanics also include a storage handle located approximately four feet from the floor. This storage handle was used to perch the hand held sprayer onto between uses. The storage of the hand held sprayer balances upon the perch. On 4/25/12 at 11:05 a.m. an observation was made of a bed pan sprayer in room #13 of the Saint (St.) Claire unit. The hand held sprayer was missing the attached lever for activating the pressure release for water use. A lever and two screws were lying on the toilet tank lid. On 4/25/12 at 11:06 a.m. an interview with the Maintenance Director indicated the lever belonged to the bed pan sprayer and looked "broken." On 4/25/12 at 11:07 a.m. an interview with the Maintenance Manager for St. Claire unit indicated a work order for			

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	repair had not been completed. On 4/25/12 at 11:08 a.m. an observation was made of the flooring in room #13 of the St Claire private Resident bathroom. An observation was made of the floor directly underneath the storage handle for the bed pan sprayer. It was observed to have numerous concave indented gashes in the linoleum type flooring. On 4/25/12 at 11:08 a.m. an interview with the Maintenance Manager for St. Claire was conducted. When questioned about the formation of the gashes, it was affirmed by the Maintenance Manager this had resulted from the hand held sprayer falling off of the handle designed for perching the sprayer for storage. When interviewed about the uses of the hand held sprayers the Maintenance Manager of St. Claire indicated the Residents usage of the bed pan sprayers to be currently used. On 4/25/12 at 11:08 a.m. an interview with the Maintenance Director was conducted about the potential hazard of the hand held bed pan sprayer falling from the storage handle and physically hitting a Resident and it was confirmed of the possibility. "... Yes, I see what you mean, it is a possibility..." It was also stated at that time that this particular			

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	portion of the building was built in "1977" and the mechanics of the bed pan sprayers were "...old and parts cannot be ordered any longer...." On 4/25/12 at 11:15 a.m. an observation of room #17 of the Saint (St.) Francis unit was conducted. It was observed that the bed pan sprayer located in the Resident's private bathroom to be broken and the "cipher brake" to be dripping water. The lever for pressing to activate the pressurized water was missing from the sprayer. The Maintenance Director noted the dripping water and indicated the "... packing needs to be tightened as well ..." On 4/25/12 at 11:30 a.m. an observation of room #11 of the Saint (St.) Paul unit was conducted. The bed pan sprayer of the Residents private bathroom was observed. The lever to the sprayer was noted to be awkward. Upon interview with the Maintenance Director is was confirmed that the lever handle was on "... backwards..." On 4/25/12 at 11:35 a.m. an observation was made for room #4. The Resident of room #4 of the St Paul unit was using the private Resident bathroom and the roommate of the same room was awaiting to use the Resident bathroom.			

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	On 4/25/12 at 12:15 p.m. an interview with the Maintenance Director and Maintenance Manager of the St. Claire unit was made indicating, "... maintenance rounds are made every Monday... and the bed pan sprayers were all working fine then... " On 4/25/12 at 4:15 p.m. an interview with the Administrator, DNS and Assistant Administrator was conducted. It was indicated that the bed pan sprayers were not a potential hazard for the Residents due to the factor that the private Resident bathrooms were not being used for private Resident usage. On 4/26/12 at approximately 11:00 a.m. an interview was conducted with the Administrator, the Assistant Administrator and the DNS. It was indicated that the St. Claire unit was actively using only one private Resident bathroom; the St. Francis unit did not use the private Resident bathrooms at all; the St. Paul and the St Anthony units used the private Resident bathrooms "...most of the time..." 3.1-45(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview the facility failed to ensure behavior monitoring for 1 of 9 residents (#34) receiving psychotropic medications in a sample of 24. Findings include: Resident #34's clinical record was reviewed on 4/24/12 at 9:00 A.M.. The record indicated the resident was admitted to the facility on 11/14/11 and had diagnoses including, but not limited to,	F0329	Resident #34 was re-evaluated to confirm that no negative outcome occurred as a result of the alleged deficiency. All other residents who receive psychotropic medications have the potential to be affected by the alleged deficiency. Inservice training will be provided to staff by 5/18/12 to ensure that any psychotropic or other medications used for behaviors will have a behavior intervention monthly flow record, see attached, included in the MAR. Pharmacy will provide a list of medications that require a	05/18/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Alzheimer's dementia with agitation and sexually inappropriate behavior due to dementia. The resident's current physician's orders from 3/25/12 indicated the resident was receiving medications including, but not limited to, Depo-Provera 200 mg by intramuscular injection every 2 months. Review of departmental notes from 12/7/11 indicated Depo-Provera was originally ordered for socially inappropriate behaviors. Review of resident #34's health care plans indicated on 11/23/11 a care plan was initiated for problem/need: "can be socially inappropriate during care towards staff by touching himself and talking in a sexual manner". Approaches included: speak to resident in a calm and direct manner; provide redirection when resident is speaking in a sexual manner; monitor resident's mood and behavior and notify MD of any significant changes; encourage resident to reminisce about the past, introduce him to like peers; if resident is being inappropriate during care then ask for another staff member for help; remind resident his behavior is inappropriate; distract resident when having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as consistent as possible. On 12/7/12 the		behavior intervention monthly flow record. The medication list will be added to the front of each MAR throughout the facility for reference. Unit nurse will ensure that all behavior intervention monthly flow records are present in the MAR monthly.Unit nurse is responsibleDON to monitorQA Team to monitor monthly	

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	155512	A. BUILDING 00 B. WING	04/26/2012

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	health care plan was updated to include use of Depo Provera. Review of the resident's behavior intervention monthly flow records included behaviors of restlessness, anxiousness, negative statements, upset when family leaves and agitation. The behavior intervention monthly flow records include interventions for each behavior and outcomes. The behavior intervention monthly flow records did not include socially inappropriate behaviors. An interview with the Social Service Director (SSD) on 4/25/12 at 10:00 A.M. indicated the nurse's do the behavior intervention monthly flow records. The SSD indicated she did not know why there was no behavior intervention monthly flow record for socially inappropriate sexual behaviors for resident #34. An interview with the unit manager, RN #1, on 4/25/12 at 10:05 A.M. indicated as far as she knew there had never been a behavior intervention monthly flow record for socially inappropriate behaviors. RN #1 indicated there should have been one. Review of the facility policy "behavioral management" dated 2/17/2000 indicated			

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	under procedure II: "observed behavior and suggested interventions for the behavior exhibited will be documented in the resident's care plan by licensed staff immediately after the behavior occurs". 3.1-48(a)(3)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interviews, the facility failed to ensure an initial nursing assessment was accurately documented regarding the presence of a pressure ulcer for 1 of 6 residents reviewed for pressure ulcers in a sample of 24. (Resident #103) Finding includes: 1. During the initial tour of the facility, conducted on 04/23/12 between 11:00 A.M. - 11:30 A.M., R.N. #2, the Unit Manager, indicated Resident #103 had an unstageable pressure ulcer on his right heel. She indicated he had been admitted with a blister on his right heel from an acute care center following surgical repair of a fractured left hip. Resident #103 was observed on 04/23/12	F0514	Resident #103 was re-evaluated to confirm that no negative outcome occurred as a result of the alleged deficiency. All other residents have the potential to be affected by the alleged deficiency. Inservice training was provided to RN #4 on how to properly complete an admission assessment on 4-25-2012, see attached. Nursing staff will utilize the admission check off list for all new admissions/readmissions, see attached. Admission nursing assessment will be completed within 24 hours of admission. Admission checkoff list will be audited on new admissions within 48 hours. Inservice training will be provided to staff by 5/18/12.Nurse responsibleDON to monitorQA Team to monitor monthly	05/18/2012

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	at 12:13 P.M., seated in his wheelchair in the dining room/lounge on the rehab unit. The resident was noted to have a quilted bootie on his right foot and a dressing was visible on the heel area. Resident #103's pressure ulcer was observed on 04/24/12 at 2:45 P.M. The resident had a rounded, silver dollar sized pressure ulcer on the bottom posterior side of his right heel. The bottom portion of the wound was a dried, brown colored fluidless blistered area the top 1/3 and a portion above the blister was noted to be covered with black, thick tissue. RN #2 indicated she would call the black area, eschar. The eschar area covered the entire top 1/3 of the original blistered area, was shaped like a button mushroom cap, and was thick and visibly rimmed on one side of the eschar area. The top of the resident's foot and toes were pink in color. The clinical record for Resident #103 was reviewed on 04/23/12 at 2:30 P.M. Resident #103 was admitted to the facility on 04/06/12 from an acute care facility with diagnoses, including but not limited to, status post left hip fracture repair, atrial fibrillation, history of a cerebral vascular accident, hypertension, and constipation. Review of an electronic Admission			

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	Assessment, completed on 04/07/12 at 2:46 A.M., by RN #4, indicated under section i. "Integumentary" the resident's skin was noted as pale in color, a bruise and incision were documented. Although there was a place to document a blister, hematoma, or pressure ulcer, none were noted. In addition, review of nursing progress notes, completed by RN #4, on 04/06/12 at 11:48 P.M., and RN #3 on 04/07/12 at 4:09 P.M., indicated both nurses documented an assessment of all of the resident's systems and body, but failed to document a blister or impaired skin on the resident's right heel. A "skin condition flowsheet", completed by RN #4, dated 04/06/12 indicated the presence of a hematoma "ota" (open to air) intact elevated with sheepskin. Review of the admission physician's orders, dated 04/06/12, indicated there were no specific orders related to the care and/or treatment of a blister on the resident's right heel. The transfer documentation from the acute care center did not mention a pressure ulcer or blister on the resident's right heel. A nursing progress note, dated 04/07/12 at 10:55 P.M. indicated the following:			

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	"...On res (resident's) right heel there is a hematoma that measures 4.5 x 5.4 x<.1. (centimeters) Heel was placed in sheep skin protector..." There was no documentation the physician was notified of the resident's pressure ulcer. Review of a treatment record for April 2012 for Resident #103 indicated a pressure relieving mattress was implemented on 04/06/12, and "Monitor hematoma to rt heel et (and) elevate with sheep skin on when in bed" was implemented on 04/07/12, a heel protector at all times was implemented on 04/10/12, and keep right lower extremity elevated in bed/wheelchair was implemented on 04/10/12. There was no documentation the physician was notified of the blister on the resident's right heel until an order for a specific treatment was received on 04/13/12. Interview with the Director of Nursing, on 04/25/12 at 9:00 A.M., indicated Resident #103 had been admitted to the facility on 04/06/12 with the blister to the right heel. A document obtained from the acute care facility, indicated the resident had a blister noted on 04/04/12. In addition, a note signed by the physician indicated he visited the resident at the facility on			

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	04/08/12 and was aware of the resident's right heel blister. The Director of Nursing, on 04/25/12 at 9:00 A.M. indicated the Admission Assessment, completed by RN #4 on 04/07/12 was inaccurately documented and she did not know why RN #3 and #4 did not mention the presence of a pressure ulcer in the progress notes until 04/07/12 at 10:55 P.M. 3.1-50(a)(1)			